

**Name:** \_\_\_\_\_  M  F  
 I prefer to be called \_\_\_\_\_  M  F  
 Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
 Single  Married  Divorced  Widowed  Separated  
**Mailing Address:** \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
**Physical Address (if different):** \_\_\_\_\_  
 \_\_\_\_\_  
 Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Mobile #: \_\_\_\_\_ Other #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ How Long? \_\_\_\_\_  
 May we call you at work?  Yes  No  
 Best time to reach you and at which phone number?  
 AM  Afternoon  PM **AND**  Home  Work  Mobile  Other  
 Email Address: \_\_\_\_\_  
 Who may we THANK for referring you? \_\_\_\_\_  
 Do you have any family members who are treated here?  
 If so, who? \_\_\_\_\_  
 Name of Person Financially Responsible: \_\_\_\_\_  
 Relationship to Patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
 If child, lives with:  Both Parents  Mom  Dad  Other

**PARENT/GUARDIAN INFORMATION:**

**Name:** \_\_\_\_\_  M  F  
 Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Birth date \_\_\_\_\_ SS # \_\_\_\_\_

**SPOUSE OR ADD'L PARENT/GUARDIAN INFORMATION:**

**Name:** \_\_\_\_\_  M  F  
 Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Birth date \_\_\_\_\_ SS # \_\_\_\_\_

**DENTAL INSURANCE**  
**Primary Dental Insurance**

Ins. Co. : \_\_\_\_\_  
 Ins. Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Ins. Phone 1: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policy Holder's Address if different from left: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Relationship to Patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
 Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_

**Secondary Dental Insurance**

Ins. Co. : \_\_\_\_\_  
 Ins. Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Ins. Phone 1: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_  
 Group #: \_\_\_\_\_  
 Policy Holder's Address if different from left: \_\_\_\_\_  
 \_\_\_\_\_  
 Phone #: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Relationship to Patient:  Self  Spouse  Parent  Other: \_\_\_\_\_  
 Birth date \_\_\_\_\_ SS # \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_

**EMERGENCY CONTACT INFO:**

In the event of an emergency, is there someone who lives near you that we should contact?  
 Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Wk #: \_\_\_\_\_ Hm #: \_\_\_\_\_

Person Filling Out Form: \_\_\_\_\_  
 Signed: \_\_\_\_\_  
 Date: \_\_\_\_\_ Relation: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
**Answer all questions by checking Yes (Y) or No (N) Y N**

Previous Dentist \_\_\_\_\_ Last dental appointment \_\_\_\_\_

Are you in good health?  Y  N  
 Has there been any change in your general health in the past year?  Y  N  
 Do you have a personal physician?  Y  N  
 Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Date of last physical exam: \_\_\_\_\_  
 Are you now under a physician's care for a particular problem?  Y  N  
 Have you ever had any serious illnesses, operations or hospitalizations?  
 If so, describe: \_\_\_\_\_  Y  N  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Do your gums ever bleed?  Y  N  
 I brush \_\_\_\_\_ times a week and floss \_\_\_\_\_ times a week.  
 Are you currently in pain?  Y  N  
 Are you apprehensive about dental work?  
 No  Slight  Moderate  Extreme  
 Are you interested in sedation dentistry?  Y  N  
 How long has it been since you had your teeth cleaned?  
 3-5 months  6-9 months  10-12 months  \_\_\_\_\_ years  Never  
 Are you interested in learning more about:  
 Invisalign  Teeth Whitening  Implants  Orthodontics  
 How often do you visit the dentist?  Never  Checkups  Regularly

**DO YOU HAVE OR HAVE YOU EVER HAD: Y N**

Rheumatic Fever or Rheumatic Heart Disease?  Y  N  
 Congenital Heart Disease?  Y  N  
 Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, Mitral Valve Prolapse?)  Y  N  
 Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?  Y  N  
 Seizures, Convulsions, Epilepsy, Fainting or Dizziness?  Y  N  
 Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?  Y  N  
 Liver Disease, Jaundice, Hepatitis A, Hepatitis B, Hepatitis C?  Y  N  
 Kidney Disease?  Y  N  
 Arthritis?  Y  N  
 Diabetes? ( Diet Controlled  Meds Controlled)  Y  N  
 Thyroid Disease, Goiter?  Y  N  
 Stomach Ulcers, Colitis?  Y  N  
 Glaucoma?  Y  N  
 Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?  Y  N  
 Chemo or Radiation treatment for Cancer?  Y  N  
 Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?  Y  N  
 Sinus or Nasal problems?  Y  N  
 Any disease, drug or transplant operation that has depressed your immune system (HIV/AIDS)?  Y  N

**OFFICE USE ONLY \* OFFICE USE ONLY**

**MEDICAL UPDATE: I have read my Health History dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.**

Date \_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Dr's Initials \_\_\_\_\_  
 Changes: \_\_\_\_\_

Date \_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Dr's Initials \_\_\_\_\_  
 Changes: \_\_\_\_\_

**ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO: Y N**

Local Anesthesia (Novocain, etc.)?  Y  N  
 Penicillin or other antibiotics?  Y  N  
 Sedatives, Barbiturates?  Y  N  
 Aspirin or Ibuprofen?  Y  N  
 Codeine or other pain killers?  Y  N  
 Latex or Rubber Products?  Y  N  
 Other allergies or reactions? Please, list: \_\_\_\_\_

**ARE YOU USING ANY OF THE FOLLOWING: Y N**

Antibiotics?  Y  N  
 Anticoagulants (Blood Thinners)?  Y  N  
 Aspirin or drugs such as Motrin, Aleve, Ibuprofen?  Y  N  
 High Blood Pressure medications?  Y  N  
 Steroids (Cortisone, etc.)?  Y  N  
 Weight loss medications (Fen-Fen)?  Y  N  
 Tranquilizers and/or antidepressants?  Y  N  
 Insulin or Oral Anti-Diabetic drugs?  Y  N  
 Digitalis, Inderal, Nitroglycerin or other heart drug?  Y  N  
 Are you taking or have you ever taken Bisphosphonates (such as Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.)?  Y  N  
 Recreational Drugs?  Y  N  
 Please list any and all medications taken, including prescription and over-the-counter medications, herbal or holistic remedies, vitamins or minerals: \_\_\_\_\_

Have you ever smoked or chewed tobacco?  Y  N  
 How much per day? \_\_\_\_\_ How long? \_\_\_\_\_  
 Do you have a history of Alcohol or Chemical Dependency or Emotional Disorder?  Y  N  
 Have you had any serious problems associated with any previous dental treatment?  Y  N  
 Have you or an immediate family member had any problem associated with intravenous anesthesia?  Y  N  
 Do you have any other disease, condition or problem not listed above that you think the doctor should know about?  Y  N  
 Do you wish to talk to the doctor privately about anything?  Y  N

**FOR WOMEN ONLY: Y N**

Are you Pregnant or is there any chance you might be Pregnant?  Y  N  
 Are you nursing?  Y  N  
 If you are using Oral Contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

**I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.**

Date \_\_\_\_\_ Signature of Person Completing Form \_\_\_\_\_ Dr's Initials \_\_\_\_\_